

**NORTHERN MONTANA HEALTH CARE
 CONSENT FOR COVID – 19 VACCINATION
 (PFIZER COVID – 19 VACCINATION)**

| | | | |
|---|-------------|----------------------|--------------|
| Name (Last, First, Middle Initial) | | Date of Birth | Phone |
| Address | City | State | Zip |
| Insurance Plan | | | |

Before agreeing to receive the vaccine, please take time to answer the following questions:

| | | | |
|----|--|-----|----|
| 1. | ALLERGIES: | YES | NO |
| | a. Do you have any SEVERE (life-threatening) allergies? | | |
| | b. Are you moderately or severely ill today? | YES | NO |

This shot is a 2-shot series given with a time frame of at least 21 days separating doses or a booster shot given 28 days to 6 months from second dose depending on special medical situations. Please read the Fact Sheet for recipients and caregivers for a list of possible side effects and the locations to report them.

I have read, or have had explained to me, the most recent Vaccine Information Statement (VIS) from the Centers for Disease Control (CDC) about COVID-19 and the COVID-19 Vaccination. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of COVID-19 vaccine and request the vaccine to be given to me or the person named below for whom I am authorized to make this request. I understand that this vaccination has been approved under the emergency use authorization program by the FDA for its booster dose and 12-16. The Pfizer vaccine for 18 and older have full FDA approval.

 Signature of person to receive vaccine or person authorized to make request

 Date

| | | |
|--|---|--|
| <p><i>For Office Use Only</i></p> <p>Administer 0.5 ml of injectable COVID-19 vaccine intramuscularly (IM) (22-25g, 1-1½ ") in deltoid muscle</p> <p>Injection Site: <input type="checkbox"/> LEFT DELTOID <input type="checkbox"/> RIGHT DELTOID</p> <p>_____ Nurse Signature</p> <p style="text-align: right;">_____/_____/_____ Date</p> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;"> Manufacturer: <u>PFIZER</u> Lot#: _____ Exp. Date: _____ </td> </tr> </table> <p>VIS Date: 5/10/21</p> | Manufacturer: <u>PFIZER</u> Lot#: _____ Exp. Date: _____ |
| Manufacturer: <u>PFIZER</u> Lot#: _____ Exp. Date: _____ | | |

Circle one: 1st SHOT 2nd SHOT 3rd SHOT Booster Dose

